STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	445456	A. BUILDING _____ B. WING _____	12/01/2010

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SWEETWATER NURSING CENTER	978 HWY 11 SOUTH SWEETWATER, TN 37874

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS An annual Recertification survey and complaint investigation #26965 were completed on November 29, 2010, through December 1, 2010, at Sweetwater Nursing Center. No deficiencies were cited related to complaint investigation #26965 under 42 CFR PART 482, Requirements for Long Term Care Facilities.	F 000	**Re: Disclaimer for Plan of Correction** Preparation and/or execution of this Plan of Correction does not constitute an admission or agreement by Sweetwater Nursing Center of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. Sweetwater Nursing Center files this Plan of Correction solely because it is required to do so for continued state licensure as a health care provider and/or for participation in the Medicare/Medicaid programs. The Facility does not admit that any deficiency existed prior to, at the time of, or after the survey. The Facility reserves the right to contest the survey findings through informal dispute resolution, formal appeal, and any other applicable legal or administrative proceedings. This Plan of Correction is not to be taken as establishing a standard of care, and the Facility submits that the actions taken by or in response to the survey findings far exceed the standard of care. This document is not intended to waive any defense, legal or equitable, in administrative, civil, or criminal proceedings.	
F 221 SS=D	483.13(a) RIGHT TO BE FREE FROM PHYSICAL RESTRAINTS The resident has the right to be free from any physical restraints imposed for purposes of discipline or convenience, and not required to treat the resident's medical symptoms. This REQUIREMENT is not met as evidenced by: Based on medical record review, facility policy review, observation, and interview, the facility failed to assess the use of a restraint for one resident (#8) of eighteen residents reviewed. The findings included: Resident #8 was admitted to the facility on October 16, 2006, with diagnoses including End Stage Renal Disease, Peripheral Vascular Disease, and Diabetes. Medical record review of the Minimum Data Set dated September 10, 2010, revealed the resident had short/long term memory problems with moderately impaired cognitive skills for daily decision making. Medical record review of the current Care Plan dated June 2010 revealed, "...Self Release Alarm Belt in wheelchair..."	F 221		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Jeffrey W. Scott — TITLE: Administrator — (X6) DATE: 12/14/2010

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F 000	INITIAL COMMENTS An annual Recertification survey and complaint investigation #26965 were completed on November 29, 2010, through December 1, 2010, at Sweetwater Nursing Center. No deficiencies were cited related to complaint investigation #26965 under 42 CFR PART 482, Requirements for Long Term Care Facilities.	F 000	The facility believes its current practices were in compliance with the applicable standard of care, but that in order to respond to this citation from the surveyors, the facility is taking the following additional actions..... **F221** **Corrective Action:** Resident #8 has been reassessed by the interdisciplinary team on 12-3-10 for the alarming self release belt to be considered a restraint due to his inability to release upon command. It was determined that resident #8 could not self release upon command. Therefore, the self release belt is considered a restraint. **Identification:** Residents currently with seat belts with Velcro and/or easy snap belts have been re-assessed on 12-3-10 by the interdisciplinary team for their ability to self-release the device and to ensure that the proper restraint or safety device is in place to meet their needs. **Measures/Systematic Changes:** Licensed nurses, C.N.A.'s, activities staff, social services, and housekeeping staff will receive in-service by the D.O.N. and /or A.D.O.N. on the restraint policy and procedure on 12-17-10, 12-22-10, 1-7-11, and 1-13-11. This in-service shall include procedure of staff reporting when restraint or safety device is not effective.	
F 221 SS=D	483.13(a) RIGHT TO BE FREE FROM PHYSICAL RESTRAINTS The resident has the right to be free from any physical restraints imposed for purposes of discipline or convenience, and not required to treat the resident's medical symptoms. This REQUIREMENT is not met as evidenced by: Based on medical record review, facility policy review, observation, and interview, the facility failed to assess the use of a restraint for one resident (#8) of eighteen residents reviewed. The findings included: Resident #8 was admitted to the facility on October 16, 2006, with diagnoses including End Stage Renal Disease, Peripheral Vascular Disease, and Diabetes. Medical record review of the Minimum Data Set dated September 10, 2010, revealed the resident had short/long term memory problems with moderately impaired cognitive skills for daily decision making. Medical record review of the current Care Plan dated June 2010 revealed, "...Self Release Alarm Belt in wheelchair..."	F 221		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Jeffrey W. Scott — TITLE: Administrator — (X6) DATE: 12/14/2010

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F 221	Continued From page 1 Medical record review revealed an assessment for the use of the restraint had not been completed. Review of facility policy Restraint, Physical revealed "...The Resident must be physically and cognitively able to self-release devices...seat belts with Velcro, or easy snap seat belts. If a resident cannot mentally and physically self-release, then the device is considered a restraint..." Observation with the Director of Nursing, on November 30, 2010, at 9:00 a.m., revealed the resident in the hall seated in a wheelchair with a self release belt in place. Further observation revealed the resident was not able to release the seat belt when asked by the Director of Nursing. Interview on November 30, 2010, at 9:00 a.m., in the hall, with the Director of Nursing, confirmed an assessment for the use of the self release belt had not been completed.	F 221	**F221 (continued)** **Monitor/Q.A.:** Interdisciplinary team will review current residents that need restraints or safety devices weekly for any new interventions that are needed. Information reviewed by the DON/ADON will be presented to the facility's Performance Improvement Committee (Administrator, D.O.N., A.D.O.N., Social Services, Admissions/Marketing Director, Dietary Manager, M.D.S. Coordinator, R.N. Assessment Nurse, Medical Records Clerk, Activity Director, Medical Director, and Pharmacy Consultant) for review and determination of ongoing compliance. **Completion Date:** January 14, 2011	1/14/11
F 315 SS=D	483.25(d) NO CATHETER, PREVENT UTI, RESTORE BLADDER Based on the resident's comprehensive assessment, the facility must ensure that a resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; and a resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore as much normal bladder function as possible. This REQUIREMENT is not met as evidenced by:	F 315		

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F 315	Continued From page 2 Based on medical record review, observation, facility policy review, and interview, the facility failed to provide a bladder training program for one resident (#3) of eighteen residents reviewed. The findings included: Resident #3 was readmitted to the facility on September 20, 2010, with the diagnosis of Subarachnoid Hemorrhage. Medcial record review of the Minimum Data Set dated June 13, 2010, revealed the resident had short/long term memory deficits and moderate cognitive impairment. Continued medical record review revealed the resident transferred with supervision, required limited assistance with ambulation, and was occasionally incontinent of bladder. Medical record review of the Minimum Data Set (MDS) dated September 26, 2010, revealed the resident had a significant change of status after sustaining a fall with a head injury on September 18, 2010. Continued medical record review revealed the resident's cognition had not changed from the MDS assessment dated June 13, 2010. Further medical record review revealed the resident had a decline in ability to perform activities of daily living, required extensive assistance with transfers, was non-ambulatory, and was always incontinent. Medical record review of an evaluation for bowel and bladder retraining and progress notes dated October 8, 2010, revealed "...Resident is unable to participate in retraining efforts of bladder due to cognitive status and functional limitations..." Continued medical record review revealed "...SCSA (significant change status assessment) -	F 315	The facility believes its current practices were in compliance with the applicable standard of care, but that in order to respond to this citation from the surveyors, the facility is taking the following additional actions..... **F315** **Corrective Action:** Resident #3 will have a voiding pattern completed and will be re-evaluated for bladder retraining. **Identification:** Residents with a significant change status assessment completed this quarter (October-December 2010) will be reviewed by January 6, 2011 by the interdisciplinary team for decline in urinary continence and need for bladder retraining. **Measures/Systematic Changes:** Assessment nurses will be in-serviced on facility policy/procedure for bladder retraining program by the D.O.N./A.D.O.N. 12-14-10 and 12-21-10. Over the next three months, the assessment nurse with the interdisciplinary team will review significant change status weekly for urinary continence declines. **Monitor/Q.A.:** A monthly cumulative report shall be presented to the Performance Improvement Committee (Administrator, D.O.N., A.D.O.N., Social Services, Admissions/Marketing Director, Dietary Manager, M.D.S. Coordinator, R.N. Assessment Nurse, Medical Records Clerk, Activity Director, Medical Director, and Pharmacy Consultant) for review and determination of ongoing compliance. **Completion Date:** January 14, 2011	1/14/11

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F 315	Continued From page 3 Will attempt to reduce urinary incontinence by routinely offering and assisting res (resident) to toilet, promptly assisting as res requests..." Review of facility policy Bladder Retraining revealed the objective was to restore the residents' ability to control urination. Observation on November 29, 2010, at 8:40 a.m., revealed the resident sitting in bed, alert, and conversive. Continued observation revealed the resident was able to demonstrate use of the call light to alert staff. Interview with the Charge Nurse at the 400 hall nurses station on December 1, 2010, at 10:20 a.m., confirmed the resident was able to make toileting needs known, including when incontinence had occurred, and required assistance from staff for transfers to the toilet and incontinence care. Interview with the Director of Nursing in the day room on December 1, 2010, at 12:30 p.m., confirmed the resident had experienced a decline in urinary continence, would be a good candidate for bladder retraining, and a voiding pattern had not been established for the resident to facilitate an individualized toileting plan to improve incontinence.	F 315	The facility believes its current practices were in compliance with the applicable standard of care, but that in order to respond to this citation from the surveyors, the facility is taking the following additional actions..... **F371** **Corrective Action:** In-service has been conducted by Dietary Manager with all Dietary Staff on 12-3-10 regarding required procedures for sanitation of pots and pans in the three compartment sink. Sign was posted on 11-30-10 to serve as a reminder of the required sanitation time for pots and pans. **Identification:** Pots and pans shall be sanitized in the three compartment sink using the required solution for 60 seconds in order to ensure required compliance. **Measures/Systematic Changes:** Staff was in-serviced on 11-30-10 and 12-3-10 by Dietary Manager on the correct way to utilize the sanitation process. This process will be added to orientation for new hires.	
F 371 SS=F	483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions	F 371		

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F 371	Continued From page 4 This REQUIREMENT is not met as evidenced by: Based on observation, review of the manufacturer's reference sheet, and interview, the facility failed to ensure cooking utensils washed received adequate immersion time in the sanitizer to effect sanitization for one of one three compartment sink. The findings included: Observation in the kitchen on November 29, 2010, at 8:25 a.m., revealed dietary aide #1 washing pots, pans, and baking sheets in the three compartment sink. Continued observation revealed the dietary aide washed, rinsed, and dipped the items in the sanitizer briefly before placing them on the rack to air dry. Observation of dietary aide #2 in the kitchen using the three compartment sink on November 30, 2010, at 11:25 a.m., revealed dietary aide #2 washed, rinsed, and swished several serving utensils in the sanitizing solution for 20 seconds before placing them on the rack to dry. Review of the manufacturer's reference sheet recommendations for sanitization revealed "...To sanitize pre-cleaned mobile items in public eating establishments (drinking glasses, dishes, eating utensils) immerse in a 200 ppm (parts per million) active quaternary solution for at least 60 seconds making sure to immerse completely..."	F 371	**F371 (continued)** **Monitor/Q.A.:** Dietary Manager and RD will observe the sanitation of pots and pans in the three compartment sink daily for two weeks, then three times per week for two weeks, then monthly, in order to ensure ongoing compliance. Results will be reported to the facility's Performance Improvement Committee (Administrator, D.O.N., A.D.O.N., Social Services Director, Admissions/Marketing Director, Dietary Manager, M.D.S. Coordinator, R.N. Assessment Nurse, Medical Records Clerk, Activity Director, Medical Director, and Pharmacy Consultant) by the Dietary Manager monthly for review and determination of ongoing compliance. **Completion Date:** December 3, 2010	12/3/10

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F 371	Continued From page 5 Interview with the Dietary Manager on November 30, 2010, at 11:30 a.m., in the kitchen confirmed the dietary staff observed had not followed the manufacturer's recommendations for sanitization.	F 371	The facility believes its current practices were in compliance with the applicable standard of care, but that in order to respond to this citation from the surveyors, the facility is taking the following additional actions.....	
F 502 SS=D	483.75(j)(1) PROVIDE/OBTAIN LABORATORY SVC-QUALITY/TIMELY The facility must provide or obtain laboratory services to meet the needs of its residents. The facility is responsible for the quality and timeliness of the services. This REQUIREMENT is not met as evidenced by: Based on medical record review and interview the facility failed to obtain lab work for one resident (#3) of eighteen residents reviewed. The findings included: Resident #3 was admitted to the facility on October 28, 2008, with diagnoses including Late Effects CVA (cerebrovascular accident), Alzheimer's Disease, Hypothyroidism, and Hypertension. Medical record review of a Physician's Order dated November 4, 2010, revealed "...CBC (complete blood count) and BMP (basic metabolic panel) in 2 wks (weeks) 11/18/10..." Medical record review of the resident's lab results revealed no results were found for the date ordered. Interview with the Assistant Director of Nursing in the day room on December 1, 2010, at 9:40 a.m., confirmed the lab work had not been obtained in November as ordered.	F 502	**F502** **Corrective Action:** Resident #3 had a BMP and CBC collected on 11-29-10. Results faxed to MD. No further orders. **Identification:** Residents with lab orders have the potential to be affected. **Measures/Systematic Changes:** 100% chart audit performed by the D.O.N./A.D.O.N. for lab orders and results from the last three months. Lab logs developed that include lab work ordered, date drawn, date returned, date MD signed, and date signed that the lab was filed in the medical record, have been placed at each nurses station. Licensed nurses will be in-serviced on maintaining the lab logs by the D.O.N. and/or the A.D.O.N. on 12-17-10, 12-22-10, 1-7-11, and 1-13-11.	

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			F502 (continued) **Monitor/Q.A.:** Charge nurses will submit copies of lab results to the D.O.N./A.D.O.N. weekly. Lab logs will be reviewed and charts audited weekly for accuracy. Cumulative monthly reports will be presented by the D.O.N./A.D.O.N. to the facility's Performance Improvement Committee (Administrator, D.O.N., A.D.O.N., Social Services, Admissions/Marketing Director, Dietary Manager, M.D.S. Coordinator, R.N. Assessment Nurse, Medical Records Clerk, Activity Director, Medical Director, and Pharmacy Consultant) for review and determination of ongoing compliance. **Completion Date:** January 14, 2011	1/14/11